NHA Billing and Coding Specialist (Sample)

Study Guide

Everything you need from our exam experts!

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Questions

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1. **Which part of Medicare is managed by private 3rd party payers?**

   A. Medicare Part A

   B. Medicare Part B

   C. Medicare Part C

   D. Medicare Part D

2. **For an office visit for a new patient, which code represents detailed history and detailed exam with moderate medical decision-making?**

   A. 99203

   B. 99204

   C. 99205

   D. 99201

3. **A billing and coding specialist is assisting a patient with a capitated health maintenance organization (HMO) who presents with a sinus infection. Which statement is true regarding a capitated HMO?**

   A. Payment is based on individual services rendered.

   B. Payment for the encounter is based on a flat rate.

   C. Patients can choose any provider.

   D. Payment is variable depending on the diagnosis.

4. **A billing and coding specialist should add modifier -50 to a code when reporting which of the following?**

   A. A bilateral procedure.

   B. A single procedure on the left side.

   C. A procedure that requires pre-authorization.

   D. A procedure that is performed in a hospital.

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5. What does the term "co-insurance" refer to in health insurance?

A. A fixed amount a patient pays for each healthcare service

B. A percentage of costs that the insured has to pay after the deductible is met

C. The total payment required before insurance kicks in

D. Payments made directly by the insurance company to a healthcare provider

6. What modifier should be used to report a mastectomy after a biopsy during the global period?

A. -56

B. -28

C. -78

D. -58

7. When should a patient typically be informed of their coinsurance responsibilities?

A. After treatment is rendered

B. Before treatment is rendered

C. Once the claim is submitted

D. When the insurance company pays

8. What is typically required in order for insurance to cover services?

A. Only in-network providers

B. A pre-authorization from the insurance provider

C. An annual membership fee

D. A co-pay at each visit

9. What does Medicare Part D cover?

A. Hospital visits

B. Prescription drugs

C. Outpatient services

D. Long-term care

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10. According to CPT integumentary coding guidelines, who are the providers involved in Mohs micrographic surgery?

A. Surgeon and nurse

B. Surgeon and anesthetist

C. Surgeon and pathologist

D. Surgeon and physician's assistant

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Answers

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1. C
2. B
3. B
4. A
5. B
6. D
7. B
8. B
9. B
10. C

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Explanations

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1. Which part of Medicare is managed by private 3rd party payers?

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

Medicare Part C, also known as Medicare Advantage, is the correct answer because it is the part of Medicare that is offered through private insurance companies approved by Medicare. These private companies manage the benefits of Medicare, allowing them to provide a variety of plan options that can include additional coverage not found in original Medicare, such as vision and dental services. Part C combines the benefits of Medicare Part A (hospital insurance) and Part B (medical insurance) into one plan and often includes a prescription drug coverage as well. Since these plans are run by private insurers, beneficiaries can choose different plans based on their health needs and financial situations. In contrast, the other parts of Medicare, such as Part A and Part B, are administered directly by the federal government. Part D, which handles prescription drug coverage, is also managed through private insurance companies, but it is separate from the combination of services offered in Part C. Thus, the defining feature of Part C is its management and availability through various private payers, making it a unique aspect of the Medicare program.

2. For an office visit for a new patient, which code represents detailed history and detailed exam with moderate medical decision-making?

A. 99203

B. 99204

C. 99205

D. 99201

The correct code for an office visit for a new patient that represents a detailed history, detailed examination, and moderate medical decision-making is indeed 99204. In the context of Evaluation and Management (E/M) coding, this code is specifically designated for new patients who require a moderate level of complexity in their care. When assigning E/M codes, documentation plays a crucial role. A detailed history indicates that the provider has collected extensive information about the patient's medical history, including a review of systems and the patient's social and family history. A detailed exam shows that the provider has conducted an in-depth physical examination to assess the patient's health status. Moderate medical decision-making involves a review of the existing problems, the amount of data to be reviewed, and the risk factors associated with the patient's condition. For a patient requiring moderate decision-making, there may be multiple problems, or a new problem that requires additional workup and management. This combination of detailed history, examination, and moderate complexity in decision-making aligns precisely with the coding characteristics of 99204, thereby making it the appropriate choice for this scenario.

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3. A billing and coding specialist is assisting a patient with a capitated health maintenance organization (HMO) who presents with a sinus infection. Which statement is true regarding a capitated HMO?

A. Payment is based on individual services rendered.

B. Payment for the encounter is based on a flat rate.

C. Patients can choose any provider.

D. Payment is variable depending on the diagnosis.

In a capitated health maintenance organization (HMO), the payment structure is characterized by a flat fee provided to healthcare providers for each patient enrolled in the plan, rather than being based on the individual services rendered during a specific visit. This means that regardless of how many services the patient utilizes over a certain period, the provider receives a set amount of payment for that patient's care. This model incentivizes providers to focus on preventive care and efficient management of resources, as they receive a predictable and stable income for their services, which can improve patient outcomes and reduce overall healthcare costs. The other options do not accurately reflect the nature of a capitated HMO. Payment based on individual services rendered implies a fee-for-service model, which is not applicable in this case. The option indicating that patients can choose any provider does not align with the HMO model, as HMOs typically restrict members to a network of chosen providers. Lastly, stating that payment varies depending on the diagnosis contradicts the flat-rate payment structure inherent to capitated plans.

4. A billing and coding specialist should add modifier -50 to a code when reporting which of the following?

A. A bilateral procedure.

B. A single procedure on the left side.

C. A procedure that requires pre-authorization.

D. A procedure that is performed in a hospital.

Using modifier -50 is appropriate for indicating a bilateral procedure, which means that the same surgical procedure is performed on both sides of the body. This modifier helps to provide clear communication to insurers that a procedure has been conducted on both sides, which is essential for proper reimbursement. It signifies that the procedure was not performed separately on each side, but rather as a single, comprehensive procedure impacting both sides. In the context of billing and coding, accurately using modifiers is crucial to reflect the services provided accurately, thereby ensuring compliance and preventing potential denials by payers. Modifier -50 is specifically assigned to bilateral procedures to distinguish them from unilateral procedures performed on just one side, which would not require this modifier. The other options do not apply because modifier -50 specifically relates to bilateral procedures and does not pertain to unilateral procedures, pre-authorization requirements, or the setting of service delivery. Thus, understanding the application of modifier -50 is vital for correct coding and billing practices in the healthcare industry.

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5. What does the term "co-insurance" refer to in health insurance?

A. A fixed amount a patient pays for each healthcare service

B. A percentage of costs that the insured has to pay after the deductible is met

C. The total payment required before insurance kicks in

D. Payments made directly by the insurance company to a healthcare provider

Co-insurance refers to the percentage of healthcare costs that the insured is required to pay after the deductible has been satisfied. It is a cost-sharing arrangement between the insurance company and the policyholder. For example, if a health insurance plan has a co-insurance rate of 20%, the insured will pay 20% of the eligible healthcare costs, while the insurance company will cover the remaining 80%. This percentage continues until the insured reaches their out-of-pocket maximum or limit. The other terms provided in the options represent different financial responsibilities in health insurance. A fixed amount that a patient pays for each healthcare service is known as a copayment, while the total payment required before insurance coverage begins is referred to as a deductible. Lastly, payments made directly by an insurance company to a healthcare provider are classified as direct payments or reimbursements, but do not define co-insurance. This understanding of co-insurance helps individuals navigate their health insurance plans and budget for potential medical expenses.

6. What modifier should be used to report a mastectomy after a biopsy during the global period?

A. -56

B. -28

C. -78

D. -58

The correct modifier to report a mastectomy after a biopsy during the global period is the -58 modifier. This modifier indicates that the surgical procedure (in this case, a mastectomy) is a staged or related procedure performed during the global period of a previous procedure (the biopsy). By using the -58 modifier, you are signaling to the payer that this is a planned procedure that is part of the treatment process following the initial biopsy and that it was appropriately scheduled according to the patient's healthcare needs. It clarifies that the mastectomy is not a complication or an unexpected outcome from the biopsy, but rather a continuation of care that should be reimbursed separately from the biopsy. Modifiers like -56, -28, and -78 serve different purposes. For example, -56 is used to indicate a pre-operative period when a service is provided that is related to the later surgical procedure but does not denote that it's related to a prior procedure. The -28 modifier is used for distinct procedural services and is not applicable here as it generally pertains to the reporting of related procedures performed on the same day. The -78 modifier indicates a return to the operating room for a related procedure during the postoperative period, which does not apply in this

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7. When should a patient typically be informed of their coinsurance responsibilities?

A. After treatment is rendered

B. Before treatment is rendered

C. Once the claim is submitted

D. When the insurance company pays

Patients should typically be informed of their coinsurance responsibilities before treatment is rendered. This is important because it allows patients to understand their financial obligations prior to receiving services. Being aware of coinsurance and other potential costs can help them make informed decisions regarding their healthcare and manage their expectations around payments. Providing this information upfront also fosters transparency between the healthcare provider and the patient, ensuring that there are no surprises after the treatment is completed. This practice aligns with good communication standards in healthcare and supports patient autonomy in managing their healthcare choices.

8. What is typically required in order for insurance to cover services?

A. Only in-network providers

B. A pre-authorization from the insurance provider

C. An annual membership fee

D. A co-pay at each visit

For insurance to cover services, obtaining a pre-authorization from the insurance provider is often a critical step. This process typically involves the healthcare provider submitting a request to the insurance company detailing the proposed treatment or procedure, along with supporting medical documentation. The insurance company then reviews this information to determine if the service meets their criteria for coverage based on medical necessity, guidelines, and the patient's specific insurance plan. Pre-authorization helps to ensure that the services are aligned with the patient's health needs and the insurance policy's provisions. It can prevent unexpected medical bills for patients, as certain procedures or treatments may only be approved for coverage if prior authorization is granted. Without this step, the insurance provider may deny claims for treatment, leading to out-of-pocket expenses for the patient. In contrast, while using in-network providers can influence whether services are covered and lower patient costs, it is not solely sufficient for coverage. An annual membership fee is not commonly a requirement in most insurance plans. Co-pays are typically a cost-sharing mechanism for services rendered but don't guarantee coverage on their own; they are often part of the patient's out-of-pocket expenses once services have been authorized and approved.

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9. What does Medicare Part D cover?

A. Hospital visits

B. Prescription drugs

C. Outpatient services

D. Long-term care

Medicare Part D specifically covers prescription drugs. It was introduced to help beneficiaries afford the medications required for various health conditions, ranging from chronic diseases to temporary ailments. The plan operates through private insurance companies, which offer different formulary options that list covered drugs, often at different tiers that affect the cost to the beneficiary. This coverage is designed to fill the gap of drug costs that are not typically covered under other parts of Medicare, such as Part A (hospital insurance) and Part B (medical insurance). Each beneficiary can choose a plan that best fits their medication needs and budget, making Medicare Part D an essential aspect of healthcare for many seniors and people with disabilities who rely on prescription medication.

10. According to CPT integumentary coding guidelines, who are the providers involved in Mohs micrographic surgery?

A. Surgeon and nurse

B. Surgeon and anesthetist

C. Surgeon and pathologist

D. Surgeon and physician's assistant

In the context of Mohs micrographic surgery, the correct answer involves the surgeon and the pathologist because this procedure requires a unique collaboration between these two professionals to ensure effectiveness and accuracy. Mohs micrographic surgery is primarily performed to treat skin cancer, and the process involves the surgeon excising cancerous skin in layers while simultaneously having those layers analyzed by a pathologist for any remaining cancer cells. The surgeon initially removes a thin layer of skin containing the tumor. After removal, the pathologist examines the tissue specimen to determine if cancerous cells remain. If traces of cancer are found, the surgeon removes another layer and this process is repeated until clear margins are achieved. This coordinated effort is crucial for the success of the surgery and for maximizing the chances of complete tumor removal. While nurses may assist during the procedure and anesthetists may be involved in administering anesthesia, they do not play key roles in the ongoing examination and assessment of the cancerous tissue that is central to Mohs surgery. Similarly, a physician's assistant may assist the surgeon but typically does not conduct the histopathological analysis that is vital to this procedure. Therefore, the collaboration between the surgeon and pathologist is what distinctly characterizes the Mohs micrographic surgery process.

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